FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0012229

Facility Name: NORWEGIAN LUTHERAN BETHESDA

Address: 2833 N. NORDICA (Number) CHICAGO (City) 60634 (Zip Code)

County: COOK

Telephone Number: (773) 622-6144 **Fax #** (773) 622-6184

IDPA ID Number: 36-2167819001

Date of Initial License for Current Owners: 06/06/59

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501(c)(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) JEFFREY K. SINGER, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 3/01/01

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	36	Skilled (SNF)	46	16,200	1
2		Skilled Pediatric (SNF/PED)			2
3	86	Intermediate (ICF)	86	31,390	3
4		Intermediate/DD			4
5	34	Sheltered Care (SC)	24	9,350	5
6		ICF/DD 16 or Less			6
7	156	TOTALS	156	56,940	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	546	914	2,318	3,778	8
9	SNF/PED					9
10	ICF	4,239	31,145		35,384	10
11	ICF/DD					11
12	SC		11,118		11,118	12
13	DD 16 OR LESS					13
14	TOTALS	4,785	43,177	2,318	50,280	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.30%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1925

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 11 and days of care provided 2,318

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	347,876	51,998	106,736	506,610		506,610		506,610			1
2	Food Purchase		267,259		267,259	(9,362)	257,897	(38,757)	219,140			2
3	Housekeeping	218,494	33,862		252,356		252,356		252,356			3
4	Laundry	49,196	9,162		58,358		58,358		58,358			4
5	Heat and Other Utilities			174,462	174,462		174,462		174,462			5
6	Maintenance	124,126		76,044	200,170		200,170		200,170			6
7	Other (specify):*											7
8	**TOTAL General Services**	739,692	362,281	357,242	1,459,215	(9,362)	1,449,853	(38,757)	1,411,096			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,913,038	149,431	81,409	2,143,878		2,143,878	(290)	2,143,588			10
10a	Therapy		92	5,592	5,684		5,684		5,684			10a
11	Activities	111,070	10,393		121,463		121,463		121,463			11
12	Social Services	25,030	692	15,990	41,712		41,712		41,712			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,049,138	160,608	114,991	2,324,737		2,324,737	(290)	2,324,447			16
	C. General Administration											
17	Administrative	118,216			118,216		118,216		118,216			17
18	Directors Fees											18
19	Professional Services			213,646	213,646		213,646	(110,526)	103,120			19
20	Dues, Fees, Subscriptions & Promotions			100,438	100,438		100,438	(49,652)	50,786			20
21	Clerical & General Office Expenses	243,977		75,953	319,930		319,930	(15,028)	304,902			21
22	Employee Benefits & Payroll Taxes			604,366	604,366	9,362	613,728		613,728			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,072	10,072		10,072	(2,841)	7,231			24
25	Other Admin. Staff Transportation			752	752		752		752			25
26	Insurance-Prop.Liab.Malpractice			72,785	72,785		72,785	(7,000)	65,785			26
27	Other (specify):*											27
28	**TOTAL General Administration**	362,193		1,078,012	1,440,205	9,362	1,449,567	(185,047)	1,264,520			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,151,023	522,889	1,550,245	5,224,157		5,224,157	(224,094)	5,000,063			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA #0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			454,757	454,757		454,757	(79,478)	375,279			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			237,441	237,441		237,441	(237,441)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			27,546	27,546		27,546	(27,546)				36
37	**TOTAL Ownership**			719,744	719,744		719,744	(344,465)	375,279			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		265,855	125,829	391,684		391,684		391,684			39
40	Barber and Beauty Shops			16,349	16,349		16,349		16,349			40
41	Coffee and Gift Shops		727	296	1,023		1,023		1,023			41
42	Provider Participation Fee			67,467	67,467		67,467		67,467			42
43	Other (specify):*	37,936			37,936		37,936	(37,936)				43
44	**TOTAL Special Cost Centers**	37,936	266,582	209,941	514,459		514,459	(37,936)	476,523			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,188,959	789,471	2,479,930	6,458,360		6,458,360	(606,495)	5,851,865			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(18,217)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(50,132)	30		9
10	Interest and Other Investment Income	(237,441)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(7,000)	26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,330)	21		24
25	Fund Raising, Advertising and Promotional	(10,664)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(15,536)	20		28
29	Other-Attach Schedule	(266,175)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (606,495)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (606,495)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

NORWEGIAN LUTHERAN BETHESDA

ID# 0012229

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Prior Licenses and Fees	$ (1,267)	20	1
2	Prior Nursing Supplies	(290)	10	2
3	Public Relations	(1,060)	20	3
4	Amortization of Bond Issuance Fees	(27,546)	36	4
5	Bond Trust Fees	(12,390)	21	5
6	Newsletter	(16,250)	20	6
7	Endowment Fund Expenses	(94,598)	19	7
8	Marketing Consultant	(15,903)	19	8
9	Marketing Salary	(37,936)	43	9
10	Dietary Supply Income	(20,540)	2	10
11	Bank Charges	(811)	21	11
12	Miscellaneous	(497)	21	12
13	Apt. Marketing Expense	(4,875)	20	13
14	Non Care Depreciation	(29,346)	30	14
15	Out of State Seminars	(2,841)	24	15
16	Prior Legal	(25)	19	16
17				17
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(38,757)											(38,757)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance													6
7	Other (specify):*													7
8	**TOTAL General Services**	(38,757)											(38,757)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(290)											(290)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(290)											(290)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(110,526)											(110,526)	19
20	Fees, Subscriptions & Promotions	(49,652)											(49,652)	20
21	Clerical & General Office Expenses	(15,028)											(15,028)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(2,841)											(2,841)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice	(7,000)											(7,000)	26
27	Other (specify):*													27
28	**TOTAL General Administration**	(185,047)											(185,047)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(224,094)											(224,094)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(79,478)											(79,478)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(237,441)											(237,441)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(27,546)											(27,546)	36
37	**TOTAL Ownership**	(344,465)											(344,465)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(37,936)											(37,936)	43
44	**TOTAL Special Cost Centers**	(37,936)											(37,936)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(606,495)											(606,495)	45

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Schedule N/A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Schedule N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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Name of Related Organization
Street Address
City / State / Zip Code
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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	IHFA Bond Issue		X	Construction and Renovation		11/99	4,015,000	3,745,000	Var	Var	236,396	6
7	CIT Financial		X	Security System	$261	12/00	13,500	10,494	11/22/05	6.00%	1,045	7
8												8
9	TOTAL Facility Related				$261		$ 4,028,500	$ 3,755,494			$ 237,441	9
	B. Non-Facility Related*											
10	See Supplemental Schedule											10
11												11
12												12
13									Interest Income		(237,441)	13
14	TOTAL Non-Facility Related						$	$			$ (237,441)	14
15	TOTALS (line 9+line14)						$ 4,028,500	$ 3,755,494			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998		10
1999		11
2000		12

Schedule N/A Non-Profit Organization

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME NORWEGIAN LUTHERAN BETHESDA COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0012229

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,403 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Apartment Building - 19 Units

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1919	$ 11,397	1
2					2
3	TOTALS			$ 11,397	3

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 a	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	43		1925	1925	$ 73,089	$	35	$	$	$ 73,089	4
5	75		1955	1955	657,001	10,108	35	10,108		467,488	5
6	40		1991	1991	2,108,648	42,470	35	70,783	28,313	719,626	6
7	-2		1997	1997	266,174	13,884	35	13,308	(576)	37,246	7
8											8
	Improvement Type**										
9	Various			1956	4,130	63	65	64	1	2,895	9
10	Various			1957	4,771		40	-		4,771	10
11	Various			1958	14,177	141	62	141		11,577	11
12	Various			1960	27,510		30	-		27,510	12
13	Various			1966	15,090		20	-		15,090	13
14	Various			1970	434		20	-		434	14
15	Various			1974	8,296		20	-		8,296	15
16	Various			1975	5,599		20	-		5,599	16
17	Various			1976	88,074		10	-		88,074	17
18	Various			1978	91,490		10	-		91,490	18
19	Various			1979	23,925		10	-		23,925	19
20	Various			1981	4,090		10	-		4,090	20
21	Various			1982	72,879		Var	-		72,879	21
22	Various			1983	8,936		Var	-		8,936	22
23	Various			1984	22,181		Var	738	738	20,162	23
24	Various			1985	8,596		Var	339	339	7,689	24
25	Various			1986	6,583		10	-		6,583	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	1986	$ 1,932,973	$ 64,751	20	$ 55,228	$ (9,523)	$ 856,034	37
38	Various	1987	6,537	218	20	187	(31)	2,711	38
39	Various	1988	50,000	2,500	20	2,000	(500)	28,750	39
40	Various	1984	1,520		20	-		1,520	40
41	Various	1990	10,600		20	530	530	6,095	41
42	Various	1990	1,442,642	55,500	20	49,172	(6,328)	501,756	42
43	Various	1992	52,486	8,933	20	1,750	(7,183)	23,379	43
44	Various	1993	59,972	6,787	20	2,999	(3,788)	29,085	44
45	Various	1994	19,138	219	20	957	738	7,340	45
46	Various	1995	80,569	6,748	20	4,029	(2,719)	25,513	46
47	Various	1996	159,908	10,259	20	7,996	(2,263)	47,976	47
48	Various	1997	152,669	12,381	20	7,651	(4,730)	33,685	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		-	-		-		-	68
69	Financial Statement Depreciation								69
70	TOTAL (lines 4 thru 69)		$ 7,480,687	$ 234,962		$ 227,980	$ (6,982)	$ 3,261,293	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,480,687	$ 234,962		$ 227,980	$ (6,982)	$ 3,261,293	1
2	Kitchen Fire Door	1998	3,402	340	20	170	(170)	553	2
3	3W Flooring	1998	22,555	2,255	20	1,128	(1,127)	3,666	3
4	Ceiling Tile	1998	5,013	501	20	251	(250)	816	4
5	2N Flooring	1998	21,140	2,114	20	1,057	(1,057)	3,259	5
6	Elevator Doors	1998	4,350	625	20	218	(407)	872	6
7	Boiler Repairs	1998	2,898	290	20	145	(145)	507	7
8	Pump Repairs	1998	1,735	173	20	87	(86)	275	8
9	Carpeting	1998	1,200	200	20	60	(140)	210	9
10	Water Heater	1998	1,499	300	20	75	(225)	231	10
11	Outside Lighting	1998	1,176	118	20	59	(59)	202	11
12	Doors and Frames	1998	2,775	277	20	139	(138)	429	12
13	Ventilation Design Drawings, Door Widening, HVAC	1998	54,461	2,723	20	1,135	(1,588)	4,540	13
14	Automatic Doors	1999	3,591	359	20	180	(179)	540	14
15	2W, 3W Decorating	1999	27,725	2,772	20	1,386	(1,386)	4,043	15
16	Vinyl Flooring	1999	4,700	940	20	235	(705)	646	16
17	Carpeting	1999	1,075	215	20	54	(161)	148	17
18	2W, 3W Bathroom Tile Repair	1999	6,150	615	20	308	(307)	695	18
19	Stair Treads	1999	470	157	20	24	(133)	62	19
20	Carpeting	1999	2,100	420	20	105	(315)	271	20
21	Roof	1999	19,300	1,930	20	965	(965)	2,412	21
22	Roof	1999	2,790	279	20	140	(139)	338	22
23	Wall Coverings	1999	890	297	20	45	(252)	105	23
24	Carpeting	1999	1,975	395	20	99	(296)	223	24
25	Floors - 2N, 2C	1999	40,299	8,060	20	2,015	(6,045)	4,534	25
26	Window Repair	1999	12,494	1,249	20	625	(624)	1,354	26
27	Sink	1999	2,643	529	20	132	(397)	275	27
28	Shower Panels	1999	5,172	1,034	20	259	(775)	527	28
29	Carpeting	1999	2,380	476	20	119	(357)	337	29
30	Drinking Fountain	1999	523	174	20	26	(148)	67	30
31	Plumbing Work	1999	1,650	550	20	83	(467)	173	31
32	Staff Dining Room	1999	1,891	378	20	95	(283)	269	32
33	Tuckpointing/Caulking	1999	7,925	763	20	396	(367)	887	33
34	TOTAL (lines 1 thru 33)		$ 7,748,634	$ 266,470		$ 239,795	$ (26,675)	$ 3,294,759	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 7,748,634	$ 266,470		$ 239,795	$ (26,675)	$ 3,294,759	1
2	Resident Telephone System	1999	31,402	3,140	20	1,570	(1,570)	3,663	2
3	Telephone Port	1999	1,733	347	20	87	(260)	181	3
4	Concrete	2000	7,391	739	20	370	(369)	740	4
5	Kitchen Insulation	2000	3,947	789	20	197	(592)	361	5
6	Carpeting	2000	2,200	440	20	110	(330)	202	6
7	Wall Coverings	2000	5,450	1,817	20	273	(1,544)	455	7
8	Door Widening	2000	2,575	257	20	129	(128)	204	8
9	Carpeting	2000	4,358	872	20	218	(654)	345	9
10	Wall Coverings	2000	3,296	659	20	165	(494)	261	10
11	Window Repair	2000	1,427	143	20	71	(72)	113	11
12	Chain Link Fence	2000	1,572	157	20	79	(78)	112	12
13	Beauty Shop Relocation	2000	7,200	720	20	360	(360)	450	13
14	Call System - Auditorium Washroom	2000	5,800	580	20	290	(290)	362	14
15	Roofing	2000	35,527	1,776	20	1,776		2,072	15
16	Outer Doors	2000	2,026	101	20	101		118	16
17	Driveway Seal Coat	2000	431	86	20	22	(64)	31	17
18	Handicap Switch	2000	784	157	20	39	(118)	55	18
19	Elevator Work	2000	900	180	20	45	(135)	53	19
20	Carpeting	2000	1,430	286	20	72	(214)	96	20
21	Bathroom Repairs	2000	660	132	20	33	(99)	44	21
22	3N Door Widening	2000	17,140	857	20	857		1,714	22
23	Lobby Renovations	2000	514,243	27,088	20	25,712	(1,376)	28,004	23
24	Boiler Replacement	2000	459,935	15,490	20	22,997	7,507	24,913	24
25	Grease Trap Replacement	2000	14,440	1,444	20	722	(722)	963	25
26	Carpeting	2000	1,387	277	20	69	(208)	81	26
27	Wallpaper	2000	1,660	332	20	83	(249)	111	27
28	Additional Cabling	2000	1,214	405	20	61	(344)	66	28
29	Code Alert System	2000	50,150	5,015	20	2,508	(2,507)	3,344	29
30	Cooler Repairs	2000	1,819		20	91	91	114	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,930,731	$ 330,756		$ 298,902	$ (31,854)	$ 3,363,987	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 8,930,731	$ 330,756		$ 298,902	$ (31,854)	$ 3,363,987	1
2	Improvements - Office	2001	4,721	944	20	236	(708)	236	2
3	Carpeting	2001	810	162	20	41	(121)	41	3
4	Stair Landing	2001	7,180	658	20	329	(329)	329	4
5	Door Replacement	2001	18,583	1,394	20	774	(620)	774	5
6	Stair Landing	2001	1,260 *	47	20	47		47	6
7	Fire Alarm Study	2001	5,000 *	125	20	125		125	7
8	4th Floor Door Replacement	2001	4,972 *	82	20	82		82	8
9	Center Bldg Nurses Station	2001	11,803 *	393	20	246	(147)	246	9
10	3N Nurse Call System	2001	2,109 *	70	20	44	(26)	44	10
11	Roof Repair	2001	6,830 *	215	20	114	(101)	114	11
12	Signage	2001	2,270 *	76	20	38	(38)	38	12
13	Roof Repair	2001	19,407 *	485	20	243	(242)	243	13
14	Faucets	2001	9,116 *	152	20	76	(76)	76	14
15	Ceiling Repair	2001	1,563 *	26	20	13	(13)	13	15
16	Telephone Wiring	2001	1,535 *	13	20	6	(7)	6	16
17	Concrete Landing	2001	8,900	296	20	445	149	445	17
18	Boiler Replacement	2001	900	30	20	45	15	45	18
19	Boiler Replacement	2001	4,053	124	20	186	62	186	19
20	Ceiling	2001	405	12	20	19	7	19	20
21	Boiler Project	2001	582 *	10	20	17	7	17	21
22	Viking Room Lighting	2001	2,191 *	110	20	64	(46)	64	22
23	Draperies	2001	1,155	115	20	58	(57)	58	23
24	Fire Alarm	2001	1,297	119	20	59	(60)	59	24
25	Walk-In Freezer	2001	942 *	16	20	8	(8)	8	25
26	Carpeting	2001	3,580	479	20	148	(331)	148	26
27	Draperies	2001	1,968	164	20	66	(98)	66	27
28	Floor Coverings	2001	4,595 *	460	20	134	(326)	134	28
29	Carpeting	2001	3,580	179	20	45	(134)	45	29
30	Draperies	2001	1,088 *	60	20	9	(51)	9	30
31	Carpeting	2001	2,770 *	92	20	23	(69)	23	31
32	Security Camera	2001	160 *	8	20	2	(6)	2	32
33	Security System	2001	13,500 *	2,700	20	675	(2,025)	675	33
34	TOTAL (lines 1 thru 33)		$ 9,079,556	$ 340,572		$ 303,319	$ (37,253)	$ 3,368,404	34

**Improvement type must be detailed in order for the cost report to be considered complete.

* Improvements added after 6/30/01

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 9,079,556	$ 340,572		$ 303,319	$ (37,253)	$ 3,368,404	1
2									2
3									3
4									4
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,079,556	$ 340,572		$ 303,319	$ (37,253)	$ 3,368,404	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 9,079,556	$ 340,572		$ 303,319	$ (37,253)	$ 3,368,404	1
2									2
3									3
4									4
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6									6
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10									10
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12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,079,556	$ 340,572		$ 303,319	$ (37,253)	$ 3,368,404	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 9,079,556	$ 340,572		$ 303,319	$ (37,253)	$ 3,368,404	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,079,556	$ 340,572		$ 303,319	$ (37,253)	$ 3,368,404	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 9,079,556	$ 340,572		$ 303,319	$ (37,253)	$ 3,368,404	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,079,556	$ 340,572		$ 303,319	$ (37,253)	$ 3,368,404	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 9,079,556	$ 340,572		$ 303,319	$ (37,253)	$ 3,368,404	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,079,556	$ 340,572		$ 303,319	$ (37,253)	$ 3,368,404	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
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51									51
52									52
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54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 974,302	$ 72,814	$ 63,979	$ (8,835)	10	$ 665,694	71
72	Current Year Purchases	61,299	7,612	3,568	(4,044)	10	3,568	72
73	Fully Depreciated Assets	88,581				10	88,581	73
74								74
75	TOTALS	$ 1,124,182	$ 80,426	$ 67,547	$ (12,879)		$ 757,843	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	General	Shuttle Van	1994	$ 34,300	$	$	$	5	$ 34,300	76
77	General	Ford Windstar	1999	22,065	4,413	4,413		5	11,769	77
78										78
79										79
80	TOTALS			$ 56,365	$ 4,413	$ 4,413	$		$ 46,069	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	10,271,500	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	425,411	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	375,279	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	(50,132)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	4,172,316	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	East Building Renovation	$ 1,478,812	$ 28,870	$ 468,956	86
87	Carpeting	1,790	238	238	87
88	Carpeting	1,790	238	238	88
89					89
90					90
91	TOTALS	$ 1,482,392	$ 29,346	$ 469,432	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	$ 326,620	92
93			93
94			94
95		$ 326,620	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 50,539	$		$ 50,539	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			2,052			2,052	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			73,238			73,238	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				246,385		246,385	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						19,470		19,470	13
14	TOTAL			$		$ 125,829	$ 265,855		$ 391,684	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 37,019	$	1
2	Cash-Patient Deposits	2,316		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 20,000)	641,227		3
4	Supply Inventory (priced at Cost)	23,582		4
5	Short-Term Investments	196,580		5
6	Prepaid Insurance	26,184		6
7	Other Prepaid Expenses	19,423		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	747		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 947,078	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	9,597,477		12
13	Land	11,396		13
14	Buildings, at Historical Cost	10,164,911		14
15	Leasehold Improvements, at Historical Cost	8,020		15
16	Equipment, at Historical Cost	1,227,193		16
17	Accumulated Depreciation (book methods)	(4,527,354)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	599,346		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	523,827		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 17,604,816	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 18,551,894	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 339,963	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	429,291		28
29	Short-Term Notes Payable	142,133		29
30	Accrued Salaries Payable	165,988		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,288		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	75,334		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	417,074		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,578,071	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	10,494		39
40	Mortgage Payable			40
41	Bonds Payable	3,602,867		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule	133,011		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,746,372	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,324,443	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 13,227,451	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 18,551,894	$	48

***(See instructions.)**

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 13,730,455	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 13,730,455	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(762,396)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants	259,392	11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (503,004)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 13,227,451	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,068,210	1
2	Discounts and Allowances for all Levels	(557,747)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,510,463	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	283,320	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 283,320	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	4,329	12
13	Barber and Beauty Care	20,656	13
14	Non-Patient Meals	18,217	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	286,312	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,889	19
20	Radiology and X-Ray		20
21	Other Medical Services	21,023	21
22	Laundry	383	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 352,809	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	(658,950)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (658,950)	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	208,322	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 208,322	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,695,964	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,459,215	31
32	Health Care	2,324,737	32
33	General Administration	1,440,205	33
	B. Capital Expense		
34	Ownership	719,744	34
	C. Ancillary Expense		
35	Special Cost Centers	446,992	35
36	Provider Participation Fee	67,467	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,458,360	40
41	**Income before Income Taxes (line 30 minus line 40)****	(762,396)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (762,396)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Non-Profit **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,916	2,136	$ 63,707	$ 29.83	1
2	Assistant Director of Nursing	2,029	2,198	51,159	23.28	2
3	Registered Nurses	19,570	20,790	453,559	21.82	3
4	Licensed Practical Nurses	17,100	18,629	356,967	19.16	4
5	Nurse Aides & Orderlies	82,326	89,373	961,084	10.75	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,132	1,350	23,963	17.75	9
10	Activity Assistants	8,916	9,783	87,107	8.90	10
11	Social Service Workers	1,383	1,552	25,030	16.13	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	4,188	4,572	58,889	12.88	14
15	Cook Helpers/Assistants	23,231	25,094	222,223	8.86	15
16	Dishwashers	6,593	7,241	66,764	9.22	16
17	Maintenance Workers	6,167	6,847	124,126	18.13	17
18	Housekeepers	20,910	22,975	218,494	9.51	18
19	Laundry	5,632	6,204	49,196	7.93	19
20	Administrator	1,892	2,208	118,216	53.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,145	12,030	243,977	20.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,856	2,072	26,562	12.82	31
32	Other Health Care(specify)					32
33	Other(specify)	1,900	2,128	37,936	17.83	33
34	TOTAL (lines 1 - 33)	217,886	237,182	$ 3,188,959 *	$ 13.45	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	424	$ 8,199	01-03	35
36	Medical Director	Mthly	12,000	09-03	36
37	Medical Records Consultant	32	1,575	10-03	37
38	Nurse Consultant	40	2,000	10-03	38
39	Pharmacist Consultant	Mthly	456	10-03	39
40	Physical Therapy Consultant	43	3,098	10a-03	40
41	Occupational Therapy Consultant	31	2,494	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	144	4,590	12-03	45
46	Other(specify)				46
47	Chaplain's Stipend	Mthly	11,400	12-03	47
48	Food Management		98,537	01-03	48
49	TOTAL (lines 35 - 48)	713	$ 144,349		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	43	$ 2,143	10-03	50
51	Licensed Practical Nurses	2,144	75,088	10-03	51
52	Nurse Aides	8	147	10-03	52
53	TOTAL (lines 50 - 52)	2,195	$ 77,378		53

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carol Page Beecher	Administrator	0	$ 118,216
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 118,216

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Klein, Dub & Holleb	Legal	$ 21,451
Ungaretti & Harris	Legal	303
James Reichardt	Legal	330
John G. Satter	Legal	313
Frost, Ruttenberg & Rothblatt	Acctg, Audit, Computer	22,231
Health Resources Alliance	Strategic Planning	32,500
ADP	Payroll Processing	15,537
RH Positive	Computer Support	4,571
Accu-Med Services	Computer Support	2,967
Stan Banash	Marketing Consultant	15,903
See Attached		97,540
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 213,646

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 77,729
Unemployment Compensation Insurance	4,291
FICA Taxes	242,963
Employee Health Insurance	250,454
Employee Meals	9,362
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	5,854
Employer 403B Contributions	23,075
TOTAL (agree to Schedule V, line 22, col.8)	$ 613,728

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	43,879
Health Care Worker Background Check	
(Indicate # of checks performed 62)	744
Dues & Subscriptions	7,694
Yellow Page Advertising	15,536
Public Relations	1,060
Advertisng	10,664
Licenses	(1,531)
Less: Public Relations Expense	(1,060)
Non-allowable advertising	(10,664)
Yellow page advertising	(15,536)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 50,786

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	7,231
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,231

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Schedule N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number NORWEGIAN LUTHERAN BETHESDA # 0012229 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $6,531**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **62,240** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **67,467**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **9,362** Has any meal income been offset against related costs? **Yes, 2-7** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Frost, Ruttenberg & Rothblatt** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees